Dr. Geri Hunter
Portsmouth Pediatric Dentistry and Orthodontics

Child

We would like to welcome you and your child to our office. Our goal is to make everyone's visit pleasant and educational. Please fill out the information below.

Date: _____

Child First, Last Name _____ Prefers to be called: _____ DOB: _____ M / F

Mailing Address: _____ City: _____ State: ___ Zip: _____ Home Phone: _____

School: _____ Grade: _____ Age: _____

Hobbies/Sports/Interests: _____

Who is accompanying this child today? _____ Relationship to Patient: _____

Does this person have legal custody of the child? Yes ☐ No ☐

Child's general dentist: _____ Date of last cleaning: _____ Pending dental work? _____

Who may we thank for referring you to our office? _____

Parents: Married ☐ Divorced ☐ Separated ☐ Other ☐

Mother - Title, First, Last Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone _____

Employer: _____ Occupation: _____

Address(if different from child): _____ City: _____ State: _____ Zip: _____

Father - Title, First, Last Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone _____

Employer: _____ Occupation: _____

Address(if different from child): _____ City: _____ State: _____ Zip: _____

Family Facts

Brothers (with ages): _____

Sisters (with ages): _____

Have any family members received orthodontic treatment? _____ Please Name: _____

Have any relatives been treated in our office? _____ Please Name: _____

What are your chief orthodontic concerns? _____

Has your child ever been evaluated for, or previously had, orthodontic treatment? _____

Dental Insurance

Name of Insured: _____ Insured Social Security #: _____

Insured's DOB: _____ Employer: _____

Insurance Company: _____ Group # : _____

Medical History:

Child's Physician: _____ Physician Phone # : _____

Date of last exam: _____ Is your child in good health? _____

Does your child have a heart condition which requires him/her to take antibiotics prior to dental treatment? YES ☐ NO ☐

Circle any of the following medical issues, which apply to your child:

Allergies	Hepatitis	Clenching/grinding teeth
Arthritis	HIV+/AIDS	Clicking/popping of jaw
Asthma	Jaundice	Jaw joint pain (TMJ)
Bleeding disorder	Migraines	Locking of jaw
Cancer	Pregnancy	Lip sucking/biting
Cold sores	Psychological issues	Mouth breather
Convulsions/epilepsy	Rheumatic fever	Nail biting
Diabetes	Sinus trouble	Snoring
Heart murmur	Tuberculosis (TB)	Speech problems
Heart disease	Venereal disease	Thumb sucking habit
		Tongue thrust

Does your child have a history of thumb or finger sucking? _____ If yes, until what approximate age? _____

Have the tonsils and/or adenoids been removed? _____

Have there been any injuries to the face, mouth, teeth or chin? If yes, describe injury and indicate age when occurred. _____

_____

Please list any medications your child is currently taking and reason for taking. _____

_____

Is your child allergic to any drugs, latex, or metals? If yes, please specify. _____

Please provide additional information on any above circled medical issues or any other conditions we should be aware of.

_____

_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's medical/dental status or personal information.

_____ _____

Signature Date